CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

March 25, 2015

Honorable John A. Boehner
Speaker
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Speaker:

Re: Cost Estimate and Supplemental Analyses for H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015

The Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have completed an analysis of H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015, as posted on the website of the House Committee on Rules on March 24, 2015. Over the 2015–2025 period, CBO estimates, enacting H.R. 2 would increase both direct spending (by about $145 billion) and revenues (by about $4 billion), resulting in a $141 billion increase in federal budget deficits (see table on page 2). Although the legislation would affect direct spending and revenues, it would waive the pay-as-you-go procedures that otherwise apply.

In addition, at your request, CBO has conducted three supplemental analyses:

- The first analysis compares the budgetary effects of the bill as a whole to those of a policy that would freeze Medicare's payment rates for physicians' services at current levels and would make none of the changes in H.R. 2. CBO estimates that enacting H.R. 2 would cost $0.9 billion less over the 2015–2025 period than freezing payment rates for physicians' services.

- The second supplemental analysis examines the effects of the bill on deficits during the decade after 2025. However, considerable uncertainty exists about the evolution of the health care delivery and financing systems that far in the future, so a precise estimate is not feasible. In CBO's assessment:

    - Enacting H.R. 2 would raise federal costs relative to current law during the decade after 2025.

    - Compared with the costs of freezing Medicare's payment rates for physicians' services, the budgetary effects of the legislation could represent net savings or net costs in the second decade after enactment, but the center of the distribution of possible outcomes is small net savings.

- The third analysis examines the effects of the bill on monthly premiums for Part B of Medicare in 2025. (Part B is Medical Insurance, which covers doctors' services, outpatient care, home health services, and other medical services.) CBO estimates that enacting H.R. 2 would raise basic monthly Part B premiums by about $10 in 2025. By comparison, CBO estimates that the basic monthly premium would increase by about $7.50 in 2025 if Medicare's payment rates for physicians' services were frozen at current levels.

SUMMARY OF ESTIMATED BUDGETARY EFFECTS OF H.R. 2, THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015, AS POSTED ON THE WEBSITE OF THE HOUSE COMMITTEE ON RULES, MARCH 24, 2015

	By Fiscal Year, in Billions of Dollars												
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2015-2020	2015-2025
CHANGES IN DIRECT SPENDING [a]													
Changes in Outlays	7.3	18.0	23.6	15.7	10.8	9.0	10.9	13.1	13.3	11.9	11.1	84.4	144.7
CHANGES IN REVENUES [b]													
Total Changes in Revenues	*	0.3	0.9	0.7	0.2	0.2	0.2	0.2	0.3	0.3	0.3	2.4	3.7
On-budget	0	0.2	0.6	0.5	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.6	2.6
Off-budget [c]	*	0.1	0.3	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.8	1.1
NET INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES													
Net Change in the Deficit	**7.3**	**17.7**	**22.7**	**14.9**	**10.6**	**8.8**	**10.6**	**12.9**	**13.0**	**11.6**	**10.8**	**82.0**	**141.0**
On-budget	7.3	17.8	23.0	15.2	10.6	8.8	10.7	12.9	13.1	11.7	10.9	82.8	142.1
Off-budget [c]	*	-0.1	-0.3	-0.2	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.8	-1.1

Sources: Congressional Budget Office and staff of the Joint Committee on Taxation.

Notes: Estimates are relative to CBO's March 2015 baseline.

* = between -$50 million and $50 million. Components may not add up to totals because of rounding.

a. Budget authority equals outlays for most spending provisions. All changes in direct spending are on-budget.

b. For revenues, positive numbers indicate a decrease in the deficit and negative numbers indicate an increase in the deficit.

c. Off-budget effects represent changes in Social Security payroll taxes.

Background on the Sustainable Growth Rate Formula

The Balanced Budget Act of 1997 (Public Law 105–33) established a formula, known as the sustainable growth rate (SGR), for setting Medicare's payment rates for physicians' services. The SGR formula was designed to ensure that real—that is, adjusted for inflation—spending per beneficiary for physicians' services would grow on average at the rate of increase in gross domestic product per capita minus the expected rate of increase in productivity for the economy as a whole.

Application of the SGR formula produced annual increases in payment rates for physicians' services through 2001, but resulted in a 4.8 percent reduction in 2002. When the SGR formula would have reduced payment rates again in 2003, that reduction was overridden by changes enacted in the Consolidated Appropriations Act (P.L. 108-7), which resulted in a 1.6 percent increase in payment rates. That was the first of 17 acts that have since overridden the SGR formula. Those overrides produced annual updates to payment rates that have ranged from a freeze to an increase of 2.2 percent—but they also provided for reductions in payment rates for physicians in subsequent years. The most recent override—enacted in the Protecting Access to Medicare Act of 2014 (P.L. 113-93)—increased payment rates by 0.5 percent for services furnished from April 1, 2014, through March 31, 2015, but it also will result in a 21 percent reduction in payment rates for physicians' services beginning on April 1, 2015.

Estimated Effects of H.R. 2 Over the 2015–2025 Period

H.R. 2 would make numerous changes to Medicare, Medicaid, and other health care and related programs. The bill would replace the SGR formula with new systems for establishing the annual updates to payment rates for physicians' services in Medicare. The bill also would temporarily extend the Children's Health Insurance Program (CHIP) and a number of other expiring provisions related to Medicare, Medicaid, and certain grant programs. In addition, it would make permanent a subsidy of Part B premiums for certain low-income Medicare beneficiaries and the availability of up to one year of additional Medicaid benefits for certain low-income families who would otherwise lose such coverage. H.R. 2 would partially offset the budgetary cost of those provisions—largely by reducing updates to Medicare's payment rates for services furnished by hospitals and providers of post-acute care and by increasing premiums paid by Medicare enrollees who have relatively high income.

The estimated budgetary effects of the legislation are summarized in the table above and are shown in more detail in the enclosed table. Several provisions would affect both direct spending and revenues; those effects are shown separately in the detailed table. The discussion below, however, focuses on net effects on the deficit—that is, the combined effect of changes in both direct spending and revenues. (CBO has not completed an estimate of the bill's effects on spending subject to appropriation.)

Medicare's Payments for Physicians' Services. Under current law, Medicare's payment rates for services furnished by physicians will be reduced by 21 percent on April 1, 2015. H.R. 2 would freeze those payment rates at current levels for three months and then increase them by 0.5 percent for services furnished during the last six months of calendar year 2015. Over the next several years, the bill would replace the SGR formula with new payment systems. CBO estimates that those changes to how Medicare sets payment rates for physicians' services would increase direct spending, relative to the current-law baseline, by about $175 billion over the 2015–2025 period.

The major provisions of the new payment systems specified in H.R. 2 are as follows:

- Medicare's payment rates for services on the physician fee schedule would increase by 0.5 percent a year for services furnished during calendar years 2016 through 2019.

  Payment rates for services on the physician fee schedule would remain at the 2019 level through 2025, but the amounts paid to individual providers would be subject to adjustment through one of two mechanisms, depending on whether the physician chose to participate in the Merit-Based Incentive Payment System (MIPS) or an Alternative Payment Model (APM) program.[1]

  For 2026 and subsequent years, there would be two payment rates for services on the physician fee schedule. For providers paid through an APM program, payment rates would be increased each year by 0.75 percent. Payment rates for other providers would be increased each year by 0.25 percent.

- Providers who participate in the MIPS program would receive payments that would be subject to positive or negative performance adjustments. The basic adjustments would be designed to be offsetting in aggregate, so that they would have no net effect on overall payments. The performance adjustment for an individual provider would depend on that provider's performance compared to a performance threshold. In addition, H.R. 2 would provide $500 million each year from 2019 to 2024 for an additional performance adjustment for providers in this program who achieved exceptional performance.

- Providers who receive a substantial portion of their revenue from alternative payment models would receive, from 2019 through 2024, a lump-sum payment equal to 5 percent of their Medicare payments in the prior year for services paid

1. A description of the APM program can be found in CBO's cost estimate for H.R. 2810, the SGR Repeal and Medicare Beneficiary Access Act of 2013, as ordered reported by the House Committee on Ways and Means; that cost estimate was issued on January 24, 2014 (see www.cbo.gov/publication/45040). Physicians who do not participate in the APM program would be in the MIPS program.

according to the physician fee schedule. Providers with smaller amounts of revenue from alternative payment models would receive either no adjustment to their payments or the MIPS performance adjustment if they reported measures and activities under that program.

Extension of the Children's Health Insurance Program. The bill would provide a total of $39.7 billion to extend CHIP through 2017. CBO and JCT estimate that enacting that provision would increase outlays by $7.0 billion and revenues by $1.4 billion, for a net cost of $5.6 billion over the 2015–2025 period relative to CBO's baseline.

The estimated cost is substantially less than the amount of funding provided for two reasons. First, pursuant to the rules that govern CBO's baseline, certain expiring programs, such as CHIP, are assumed to continue in the baseline beyond the scheduled expiration date. In accordance with those rules, CBO's most recent baseline projections reflect the assumption that funding in each year over the 2016–2025 period will be equal to a portion of the funding provided for CHIP in 2015—$5.7 billion out of the total of $21.1 billion. CBO's estimate of spending under this bill is net of that spending already assumed in the baseline.

Second, the increase in spending for CHIP would be partially offset by reductions in the net costs of federal subsidies provided for other forms of health insurance, including Medicaid, insurance purchased through the exchanges established under the Affordable Care Act, and employment-based health insurance. Those reductions would occur because most of the people who would receive coverage through CHIP as a result of enacting H.R. 2 would otherwise have received coverage from one of those other sources.

Extension of Expiring Provisions Related to Medicare. Several Medicare provisions, including some that increase payments for certain hospitals, physicians, and ambulance providers, will expire on April 1, 2015. H.R. 2 would extend those increases through the end of either fiscal year 2017 or calendar year 2017, depending on whether Medicare's payment system for that type of provider operates on a fiscal year or calendar year basis. The bill also would extend for two years the eligibility of certain types of managed care plans to participate in the Medicare program. CBO estimates that enacting those provisions (subtitle A of title II) would increase direct spending by $6 billion over the 2015–2025 period.

Other Health Care Extensions and Miscellaneous Provisions. H.R. 2 would also extend a number of programs administered by the Centers for Medicare & Medicaid Services (under the Medicaid program), the Administration for Children and Families, the Health Resources and Services Administration, and other agencies of the Department of Health and Human Services. In general, the bill would extend those programs for two additional years—through fiscal year 2017. The legislation also would modify several

Medicare program rules and would extend a program that supports rural schools. CBO estimates that enacting those provisions would increase direct spending by about $27 billion over the 2015–2025 period. (That amount encompasses the items under subtitle B of title II and title V, except for the effect, discussed below, of permanently extending one program—Transitional Medical Assistance (TMA)—that would reduce deficits.)

Those provisions include the following:

- H.R. 2 would permanently extend the Qualifying Individuals Program, which subsidizes Medicare Part B premiums for certain low-income Medicare beneficiaries. CBO estimates that enacting this provision would increase direct spending by $14.6 billion over the 2015–2025 period.

- The bill would provide funding for five grant programs administered by the Health Resources and Services Administration, including ones that provide funding for health centers and the National Health Service Corps. CBO estimates that enacting those provisions would cost $8.7 billion over the 2015–2025 period.

- Other provisions account for the remaining $3.4 billion in costs over the 2015–2025 period. Those provisions include changes in Medicare rules related to program integrity and payment for surgical services. They also include extensions of funding for the following: diabetes research programs of the National Institutes of Health; diabetes treatment, education, and prevention programs for American Indian and Alaska Native populations; allotments to Tennessee for disproportionate share hospitals; and support for rural schools.

Policies that Would Reduce Direct Spending or Increase Revenues. H.R. 2 includes several provisions that would generate budgetary savings over the next decade. In aggregate, CBO estimates that those provisions, in titles II, IV, and V, would result in outlay reductions and revenue increases yielding savings totaling about $73 billion over the 2016–2025 period, mostly in the later part of that period. The largest savings would result from:

- Increasing premiums that certain beneficiaries with relatively high income pay to participate in Part B and Part D (which covers outpatient prescription drugs) of Medicare, beginning in 2018; and increasing the number of beneficiaries subject to those income-related premiums beginning in 2020. CBO estimates that those changes would increase offsetting receipts, and thereby reduce direct spending, by $34.3 billion over the 2018–2025 period.

- Reducing the updates to Medicare's payment rates in 2018 for certain providers of post-acute-care and long-term-care services to 1 percent. CBO estimates that those provisions would reduce direct spending by $15.4 billion over the 2018–2025 period.

- Replacing a 3.2 percent increase in payment rates for hospital inpatient services that is scheduled for 2018 with an increase of 0.5 percent each year from 2018 through 2023. That provision would reduce direct spending by $15.1 billion over the 2018–2025 period, CBO estimates.

- Changing state allotments for Medicaid disproportionate share hospital (DSH) payments. Under current law DSH allotments are increased each year by the percent change in the consumer price index and then adjusted by scheduled cuts. Relative to current law, H.R. 2 would increase net allotments in the first few years of the budget window and decrease net allotments in later years. CBO estimates that those provisions would reduce direct spending by $4.1 billion over the 2016–2025 period.

- Making permanent a provision regarding TMA under Medicaid, which requires states to provide continued medical coverage for certain families who become ineligible for medical assistance because of increased earnings. Permanently extending TMA would increase spending for Medicaid because more families would be covered. As a result, however, some of those families would no longer receive subsidies for coverage purchased through health exchanges or employers. By CBO and JCT's estimate, the increased costs for Medicaid would be more than offset by a decline in the net costs of federal subsidies provided for insurance offered through exchanges and employment-based insurance. On net, the provision is estimated to reduce the deficit by $2.8 billion over the 2015–2025 period.

Other provisions, including a limit on first-dollar coverage by certain medigap policies sold to individuals who enroll in Medicare after 2019 and an increase in the proportion of payments to Medicare providers that could be withheld to satisfy delinquent tax debt, account for the remaining $1 billion in budgetary savings, CBO and JCT estimate.

Supplemental Analyses
As you requested, CBO has conducted three supplemental analyses:

- Comparing the budgetary effects of the bill with those of a policy that would freeze Medicare's payment rates for physicians' services at current levels without making any of the changes in H.R. 2;

- Examining the effects of the bill on deficits during the decade after 2025; and

- Examining the effects of the bill on basic monthly premiums for Part B of Medicare in 2025.

Comparing the Budgetary Effects of H.R. 2 With the Effects of a Freeze in Physicians' Payment Rates. You asked CBO to identify how much the budgetary effects of the bill would exceed the costs of cancelling the scheduled reduction in physicians' payment rates and freezing those rates at current levels.

CBO estimates that freezing Medicare's payment rates for physicians' services at current levels would increase deficits by $141.9 billion over the 2015–2025 period. The total budgetary cost of H.R. 2 comes to $141.0 billion over that period. Thus, CBO estimates that enacting the legislation would cost $0.9 billion less over the 2015–2025 period than freezing Medicare's payment rates for physicians' services (see the Memorandum section at the bottom of the enclosed table).

Budgetary Effects of H.R. 2 in the Decade Following 2025. As you requested, CBO examined the effects of the legislation over the decade after 2025, and compared those effects with the costs of freezing Medicare's payment rates for physicians' services at current levels. CBO's detailed baseline projections do not extend beyond 2025, but the agency has constructed an extended baseline that generally extrapolates the baseline concept into later years.[2] Because of the considerable uncertainty that exists about the evolution of the health care delivery and financing systems, the extended baseline of federal spending for health care programs employs a formulaic approach. To respond to your request, CBO used the approach underlying the extended baseline to make a rough extrapolation of the budgetary effects of H.R. 2.

CBO's first step in making that extrapolation was to adjust the bill's estimated effect on deficits in 2025 to remove the impact of a provision—the adjustment of Medicaid DSH payments—that would not have a budgetary effect during the subsequent decade. Apart from the effects of that provision, H.R. 2 would increase the budget deficit in 2025 by $14.9 billion, by CBO's estimate. That amount can be viewed as an increase of $17.5 billion in the deficit if Medicare's payment rates for physicians' services were maintained at current levels and a decrease of $2.6 billion in the deficit from other aspects of the bill.

2. CBO has not yet fully updated the long-term projections that were published in Congressional Budget Office, *The 2014 Long-Term Budget Outlook* (July 2014), www.cbo.gov/publication/45471. The extended baseline used in this analysis applies the interest rates and growth rates for revenues and spending from the extended baseline in last year's report to the 10-year projections published by CBO in January 2015. For details about how CBO constructed its long-term projections for federal spending for health care programs, see Chapter 2 of last year's report.

The second step in CBO's extrapolation of the budgetary effects of the bill was to extrapolate the effects of the key provisions from 2025 through 2035. The budgetary effects of two provisions of the bill would increase especially rapidly: The effect of the increase in the number of beneficiaries subject to income-related premiums for Parts B and D of Medicare would grow rapidly because the share of Medicare enrollees subject to those surcharges would rise over time; similarly, the effect of the limitation on first-dollar coverage by certain medigap plans would grow rapidly because the policy would apply only to beneficiaries who enroll after 2019. CBO also took into account that Medicare's payment rates for physicians' services would probably be higher and would probably grow more rapidly under the legislation than under current law, and extrapolated the relatively small budgetary effects of other provisions of the legislation using the growth rates of overall Medicare spending in the extended baseline.

Estimates of the budgetary effects of H.R. 2 are very uncertain, because of both uncertainty about future federal health care spending under current law and the difficulty of projecting such spending under the alternative payment rules for providers and costs for beneficiaries that would be established under the legislation. Estimates of those effects two decades into the future are especially uncertain. Nonetheless, based on the methodology described here, CBO's assessment is that:

- Taken as a whole, H.R. 2 would raise federal costs (that is, increase budget deficits) relative to current law in the second decade after enactment. The budgetary effects of some provisions of the bill that would generate federal savings would increase rapidly in that decade, but they would be growing from a much smaller starting point in 2025 than the budgetary effects of the provisions generating additional federal costs.

- Compared with the costs of freezing Medicare's payment rates for physicians' services, the budgetary effects of H.R. 2 could represent net savings or net costs in the second decade after enactment, but the center of the distribution of possible outcomes is small net savings.

Effects of H.R. 2 on Monthly Premiums for Part B of Medicare. Beneficiaries enrolled in Medicare pay a "basic" monthly premium that is set to cover about 25 percent of the costs of Part B. (Beneficiaries with relatively high income also pay an additional income-related premium.) The basic monthly Part B premium for calendar year 2015 is $104.90. Under current law, CBO projects that the Part B premium will rise to $171 in 2025. By CBO's estimate, enacting H.R. 2 would result in an increase of about $10—to $181—in the basic monthly Part B premium for 2025. By comparison, CBO estimates that the basic monthly premium would increase by about $7.50 in 2025 if Medicare's payment rates for physicians' services were frozen at current levels.

If you wish further details, we would be happy to provide them. CBO's primary staff contacts for this estimate and associated analyses are Holly Harvey, Tom Bradley, and Chad Chirico.

Sincerely,

Douglas W. Elmendorf

Douglas W. Elmendorf
Director

Enclosure

cc: Honorable Nancy Pelosi
Democratic Leader

Changes in Direct Spending and Revenues Under H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015, as Posted on the Website of the House Committee on Rules, March 24, 2015

	By Fiscal Year, in Billions of Dollars											Total	
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2015-2020	2015-2025
CHANGES IN DIRECT SPENDING[a]													
TITLE I—SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION	6.0	11.4	11.4	11.7	13.9	15.3	18.4	20.6	21.7	22.0	23.3	69.5	175.4
TITLE II—MEDICARE AND OTHER HEALTH EXTENDERS													
Subtitle A—Medicare Extenders (b)													
201. Work GPCI floor	0.2	0.4	0.4	0.1	0	0	0	0	0	0	0	1.1	1.1
202. Therapy cap exceptions process	0.2	0.8	0.6	0.2	0	0	0	0	0	0	0	1.9	1.9
203. Ambulance add-ons	*	0.1	0.1	*	0	0	0	0	0	0	0	0.4	0.4
204. Increased inpatient hospital payment adjustment for certain low-volume hospitals	0.1	0.4	0.4	*	0	0	0	0	0	0	0	1.0	1.0
205. Medicare-dependent hospital program	0.1	0.2	0.2	*	0	0	0	0	0	0	0	0.4	0.4
206. Specialized Medicare Advantage plans for special needs individuals	0	0	0.2	0.3	0.1	0	0	0	0	0	0	0.6	0.6
207. Funding for quality measure endorsement, input, and selection	*	*	*	*	0	0	0	0	0	0	0	0.1	0.1
208. Funding outreach and assistance for low-income programs	*	*	*	0	0	0	0	0	0	0	0	0.1	0.1
209. Reasonable cost reimbursement contracts	0	0	0.1	0.1	0.1	*	*	*	*	*	*	0.2	0.3
210. Home health rural add-on	0	0.1	0.1	*	0	0	0	0	0	0	0	0.2	0.2
Subtitle B—Other Health Extenders													
211. Permanent extension of the Qualifying Individual program	0.4	0.7	0.9	1.0	1.1	1.3	1.5	1.7	1.8	2.0	2.2	5.4	14.6
212. Permanent extension of Transitional Medical Assistance (c)	0.1	0.4	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	*	-1.2
213. Special diabetes program for type I diabetes and for Indians	0	0.2	0.3	0.1	*	*	0	0	0	0	0	0.6	0.6
214. Abstinence education	0	*	*	0.1	*	*	*	0	0	0	0	0.1	0.1
215. Personal responsibility education program	0	*	*	0.1	*	*	0	0	0	0	0	0.1	0.1
216. Funding for family-to-family health information centers	*	*	*	*	*	*	0	0	0	0	0	*	*
217. Health workforce demonstration project for low-income individuals	0	*	*	0.1	0.1	*	0	0	0	0	0	0.2	0.2
218. Maternal, infant, and early childhood home visiting programs	0	*	0.1	0.3	0.2	0.1	0	0	0	0	0	0.7	0.7
219. Tennessee DSH allotment for fiscal years 2015 through 2025	0.1	*	*	*	*	*	*	*	*	*	*	0.3	0.5
220. Delay in effective date for Medicaid amendments relating to beneficiary liability settlements	0	*	*	*	0	0	0	0	0	0	0	0.1	0.1
221. Funding for Community Health Centers, National Health Service Corps, and Teaching Health Centers	0	1.9	3.6	2.1	0.4	*	*	*	*	*	*	8.0	8.0
TITLE III—CHILDREN'S HEALTH INSURANCE PROGRAM (c)													
Effect on CHIP, Medicaid, and exchanges of extending CHIP for two years	0	0.9	3.7	2.4	*	0	0	0	0	0	0	7.0	7.0

Continued

H.R. 2 Continued

	By Fiscal Year, in Billions of Dollars												
	2015	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2015-2020**	**2015-2025**
TITLE IV—OFFSETS													
Subtitle A—Medicare Beneficiary Reforms													
401. Limitation on certain Medigap policies for newly eligible Medicare beneficiaries	0	0	0	0	0	*	*	*	-0.1	-0.1	-0.1	*	-0.4
402. Income-related premium adjustments for Parts B and D	0	0	0	-0.8	-1.2	-3.5	-4.6	-5.2	-5.8	-6.3	-7.0	-5.5	-34.3
Subtitle B—Other Offsets													
411. Medicare payment updates for post-acute providers	0	0	0	-1.2	-1.6	-1.7	-1.9	-2.1	-2.2	-2.2	-2.5	-4.6	-15.4
412. Delay of reduction to Medicaid DSH allotments	0	0	1.2	2.4	1.6	0.7	-0.2	-0.9	-1.8	-3.0	-4.1	5.8	-4.1
414. Adjustments to inpatient hospital payment rates	0	0	0	-3.5	-3.6	-3.0	-2.3	-1.5	-0.5	-0.4	-0.4	-10.1	-15.1
TITLE V—MISCELLANEOUS													
Subtitle A— Protecting the integrity of Medicare (c)	*	0.1	0.1	0.1	*	-0.2	*	*	*	*	*	0.1	0.1
Subtitle B— Other provisions													
521. Extension of two-midnight PAMA rules on certain medical review activities	*	0	0	0	0	0	0	0	0	0	0	*	*
523. Payment for global surgical packages	0	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.6	1.5
524. Extension of Secure Rural Schools and Community Self-Determination Act of 2000	0.2	0.2	*	0	0	0	0	0	0	0	0	0.5	0.5
525. Exclusion from PAYGO scorecards	0	0	0	0	0	0	0	0	0	0	0	0	0
Interaction:													
Independent Payment Advisory Board	0	0	0	0	-0.3	-0.1	-0.1	0.4	*	-0.1	-0.2	-0.4	-0.3
Total Changes in Direct Spending Outlays (d)	**7.3**	**18.0**	**23.6**	**15.7**	**10.8**	**9.0**	**10.9**	**13.1**	**13.3**	**11.9**	**11.1**	**84.4**	**144.7**
CHANGES IN REVENUES[d]													
Permanent extension of TMA (c)													
On-budget	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.5	1.1
Off-budget (e)	0	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6
Children's Health Insurance Program (c)													
On-budget	0	0.1	0.4	0.3	*	*	0	0	0	0	0	0.9	0.9
Off-budget	*	*	0.2	0.2	*	0	0	0	0	0	0	0.5	0.5
Levy on delinquent providers	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.6
Protecting the integrity of Medicare (c)	0	*	*	*	*	*	*	*	*	*	*	*	*
Requiring bid surety bonds and state licensure for entities submitting bids under the Medicare DMEPOS competitive acquisition program	0	0	0	0	*	*	*	*	*	*	*	*	*
Total Changes in Revenues	*****	**0.3**	**0.9**	**0.7**	**0.2**	**0.2**	**0.2**	**0.2**	**0.3**	**0.3**	**0.3**	**2.4**	**3.7**
On-budget	*0*	*0.2*	*0.6*	*0.5*	*0.2*	*0.2*	*0.2*	*0.2*	*0.2*	*0.2*	*0.2*	*1.6*	*2.6*
Off-budget	*	*0.1*	*0.3*	*0.2*	*0.1*	*0.1*	*0.1*	*0.1*	*0.1*	*0.1*	*0.1*	*0.8*	*1.1*
NET INCREASE OR DECREASE (-) IN DEFICITS FROM CHANGES IN DIRECT SPENDING AND REVENUES													
Net Change in the Deficit	**7.3**	**17.7**	**22.7**	**14.9**	**10.6**	**8.8**	**10.6**	**12.9**	**13.0**	**11.6**	**10.8**	**82.0**	**141.0**
On-budget	*7.3*	*17.8*	*23.0*	*15.2*	*10.6*	*8.8*	*10.7*	*12.9*	*13.1*	*11.7*	*10.9*	*82.8*	*142.1*
Off-budget	*	*-0.1*	*-0.3*	*-0.2*	*-0.1*	*-0.1*	*-0.1*	*-0.1*	*-0.1*	*-0.1*	*-0.1*	*-0.8*	*-1.1*

Continued

H.R. 2 Continued

	By Fiscal Year, in Billions of Dollars												
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2015-2020	2015-2025
Memorandum													
Cost of freezing Medicare's payment rates for physicians' services	5.8	11.0	10.6	10.6	11.6	12.7	13.9	15.6	16.2	16.3	17.5	62.4	141.9
Change in unified-budget deficits under H.R. 2 less the cost of a freeze in the physician fee schedule	1.5	6.7	12.1	4.4	-1.1	-4.0	-3.3	-2.7	-3.2	-4.7	-6.7	19.6	-0.9

Sources: Congressional Budget Office and staff of the Joint Committee on Taxation.

Notes: Estimates are relative to CBO's March 2015 baseline.

* = between -$50 million and $50 million. Components may not add up to totals because of rounding.

CHIP = Children's Health Insurance Program;
DMEPOS = durable medical equipment, prosthetics/orthotics and supplies;
DSH = disproportionate share hospital;
GPCI = geographic cost-of-practice indices;
PAMA = Protecting Access to Medicare Act of 2014 (Public Law 113-93);
PAYGO = pay-as-you-go;
SGR = sustainable growth rate;
TMA = Transitional Medical Assistance;
TRICARE = the health plan operated by the Department of Defense.

a. Budget authority equals outlays for most spending provisions. All changes in direct spending are on-budget. CBO has not estimated the effects of the legislation on spending subject to appropriation.

b. All Medicare provisions include interactions with Medicare Advantage payments, the effect on Medicare Part A and Part B premiums, and TRICARE.

c. Proposal would affect both direct spending and revenues, which are shown separately.

d. For revenues, positive numbers indicate a decrease in the deficit and negative numbers indicate an increase in the deficit.

e. Off-budget effects represent changes in Social Security payroll taxes.